

"Creating healthy, beautiful smiles....for a lifetime."

**Insurance Information**

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ SS# \_\_\_\_\_

Employed by: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Insurance Contact person or department: \_\_\_\_\_

Your relationship to the insured: \_\_\_\_\_

If patient is a minor, name and address of responsible party for payment: \_\_\_\_\_

\_\_\_\_\_ Relationship: \_\_\_\_\_

**Primary Insurance Company Name:** \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Group# : \_\_\_\_\_ Policy# : \_\_\_\_\_

Do you have secondary dental insurance coverage? Yes \_\_\_ No \_\_\_ If so, with whom? \_\_\_\_\_

\_\_\_\_\_

**Coverage**

Preventive \_\_\_\_\_ Cal. Year \_\_\_\_\_

Basic \_\_\_\_\_ Deductable \_\_\_\_\_

Major \_\_\_\_\_ Maximum \_\_\_\_\_

Ortho \_\_\_\_\_ Other \_\_\_\_\_

Acknowledgement \_\_\_\_\_

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I herby certify that the above information is correct. It is the patient's responsibility to file their own secondary dental insurance coverage. I understand that insurance may not cover all costs of treatment and I agree to pay my balance, 1% interest/month, and/or all costs of collection insured by Dr. Joseph Smith, DDS. A \$25.00 fee is charged for appointments canceled or broken without 24 hours advance notice.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_